



Scoliosis Research Society
555 East Wells St, Suite 1100
Milwaukee, WI 53202-3823 USA
Phone: 1 414 289 9107
Fax 1 414 276 3349

Scoliosis Research Society Patient Story/Case Study Submission Form

NOTE: The purpose of collecting these stories is for their use in several SRS activities, i.e. Web, coffee table book, film brochures, philanthropy materials and other venues as appropriate. In addition, these stories could be used in SRS publications, in public service ads, or in patient advocacy activities.

Permission by the patient is required to submit their story.

Orthopaedic Surgeon:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____
Email: _____

Patient:

Name: _____
Address: _____
City/State/Zip: _____
Condition: _____
Age: _____
Occupation: _____

Patient agrees to have their information submitted to possibly be used in the variety of activities listed above. (*Permission is not necessary prior to submitting your story, but must be obtained prior to using.*): _____ YES _____ NO _____ In Process

You have before and after pictures (if they help to illustrate the story): _____ YES _____ NO

Optional:

Ethnic Diversity: _____ Gender: _____

Case History (Please use a separate sheet of paper and attach as many as you need.):

Tell us: What was the patient's problem when they presented?
What bothered the patient before surgery?
What was the treatment/surgeries/etc.?
How is the patient better after surgery?
What difference did you make in their life?

RETURN TO:
Tressa Goulding
555 E Wells Street, Suite 1100
Milwaukee, WI 53202
Fax: (414) 276-3349
Email: tgoulding@srs.org

Remember to include any extra pages of description, background, photos, etc.